MENTAL HEALTH PLANNING AND ADVISORY COUNCIL
January 15, 2014, 9:00 am to 3:30 pm
United Way Conference Center, Room F
1111 9th Street, Des Moines, Iowa
MEETING MINUTES

MHPC MEMBERS PRESENT:

Teresa Bomhoff
Kenneth Briggs, Jr.
Jim Chesnik (by phone)
Ron Clayman (by phone)
Jackie Dieckmann
Jim Donoghue
Kris Graves
Julie Kalambokidis (by phone)
Gary Keller (by phone)
Sharon Lambert (by phone)
Todd Lange (by phone)
Amber Lewis (by phone)
Sally Nadolsky
Todd Noack
Lori Reynolds (by phone)
Donna Richard-Langer
Jim Rixner
Lee Ann Russo
Joe Sample
Dennis Sharp
Kathy Stone (by phone)
Kim Wilson (by phone)

MHPC MEMBERS ABSENT:

Nancy Anders
John Eveleth
Virgil Gooding
Diane Johnson
Doug Keast
Brad Richardson
Christina Schark
Kimberly Uhl
Ann Wood

OTHER ATTENDEES:

Theresa Armstrong	DHS, MHDS, Community Services & Planning Bureau Chief
Danielle Cusack	Brain Injury Alliance of Iowa
Connie Fanselow	DHS, MHDS, Community Services & Planning
David Lange	Office of Consumer Affairs
Laura Larkin	DHS, MHDS, Community Services & Planning
Geoff Lauer	Brain Injury Alliance of Iowa

COMMITTEE WORK - Time was available from 9:00 am to 10:00 for committee meetings.

WELCOME & INTRODUCTIONS - Teresa Bomhoff called the meeting to order at 10:00 a.m. and led introductions, with eight members present and six members participating by phone. Action items were postponed until a quorum of 21 members could be established.

Nominations Committee Report - Dennis Sharp reported that there is a vacancy for a parent of a child with SEC and applications are needed. Connie Fanselow said that DHS is finalizing its recommendation for a mental health state agency representative and a person should be named before the next meeting.

Monitoring & Oversight Committee Report – Connie Fanselow reported from the notes of the last meeting in December. Currently the committee has been challenged in getting more than two members together for a discussion. They want to work on defining there role with regard to the Block Grant and Block Grant contracts. They are interested in providing recommendations on how they would like to see Block Grant funds used that the Council can support and pass on to DHS to consider as new contracts are considered and developed.

Historically the M & O Committee worked to review existing contracts and spending, but members are now more interested in being proactive and making recommendations to the Department about how they would like to see Block Grant contacts moving in the future. That could include what kinds of CMHC services or training they would like to see targeted and what kinds of initiatives, projects, or technical assistance they would like to see supported. Peer support is one area that has been discussed previously. At the last meeting Todd Noak also suggested expanding Mental Health First Aid training and Youth MHFA training to make it available on a statewide and ongoing basis. Once a majority of M & O Committee members can together and have a full discussion, they will formulate recommendations to present to the full Council for review.

Teresa Bomhoff proposed asking Karen Hyatt to come the next meeting and update the Council on MHFA and related training. Julie Kalambokidis said she is trained in MHFA and that she has gotten a grant to take the youth training.

Teresa also suggested asking Mary Mohrhauser to come to the next meeting and give an update on how the Block Grant money is currently being spent, what the CMHCs are doing with their 70%, and what the 25% is supporting.

Veterans Workgroup Report – Ken Briggs reported that things at the Iowa Veterans Home are more relaxed and that change seems to be coming. Teresa noted that the Governor is proposing legislation that would make veterans' pensions non-taxable in Iowa. Ken said he would check on how the Governor's budget provides for the IVH. Teresa said she is interested in visiting the IVH and will look into possibly arranging a visit for the July meeting.

Several members joined the meeting at 10:30 and quorum was established with eleven members present and ten on the phone.

Approval of Minutes – No corrections or additions to the minutes were offered. Donna Richard-Langer made a motion to approve the minutes of the November 20, 2013 meeting as presented. Jim Rixner seconded the motion. The motion passed unanimously.

Corrections Workgroup – Jackie Dieckmann reported that the group has not met for a while and there is no update.

Jim Rixner commented that he heard Jennifer Vermeer say that IME/DHS is looking at funding people in community corrections. He also said that individuals in residential treatment centers have not been covered by Medicaid, but now will be eligible for expanded Medicaid benefits. Teresa Bomhoff said she had recently attended a meeting of the Polk County Criminal Justice Committee and they were looking at how to get people enrolled. They were concerned about getting the information out to people so they know they can apply and making sure they have whatever help they need to go through the process. Jim said that the community mental health centers are working on it. He said there is confusion everywhere about the new Medicaid program and he expects it will take five years or more to reach most of the people who qualify and get them all signed up for benefits. He noted that a number of people may be denied county funded services, yet may not actually get enrolled in Medicaid.

Gary Keller said he and his colleagues are constantly in contact with their patient advocates and are confused with Medicaid advocacy themselves. He said they had some success in December in finding placements. He noted that the forensic unit at Oakdale is technically part of the prison so those they are trying to place are not eligible until they actually step foot outside of the facility and then they have to wait 90 days after getting their discharge papers to be eligible for benefits.

Teresa commented that those who are currently paying for the treatment needs of this population ought to be motivated to get them signed up. She said that she would like Council members to contact jails and judicial committees, county boards of supervisors, and others and encourage them to get the information and assist with getting people signed up. She asked if there is a packet of information available from IME that would help people learn how to apply. Sally Nadolsky responded that she could pull together the basic documents, including the application and medically exempt determination form and share them with the Council.

Legislative Priorities Committee Report – Teresa Bomhoff said she has sent out three emails on mental health parity at the federal level. She said that while Iowa Medicaid follows mental health parity, it does not apply to the federal Medicaid and Medicare programs. Jim Rixner commented that Medicare still pays very little for mental health services and any movement to increase that amount would be helpful. He said that private providers often do not want to take people with Medicare because the reimbursement rate is so low. Some of those people go to CMHCs and get services,

but the CMHCs need to receive a level of reimbursement that will allow them to keep functioning and keep the doors open.

Teresa noted that the Governor's budget included $30 million for county equalization payments. She recommended that Council members read the InfoNet newsletters to keep updated on what is going on at the Capitol, including the Guide to the Iowa Legislature, which is available online. It contains pictures and contact information for legislators and shows their committee memberships.

Joe Sample said that the DD Council also has a Facebook page where Rik Shannon posts items of interest, which is especially helpful when things are happening quickly during the legislative session.

SUICIDE PREVENTION AND TRAUMA-INFORMED CARE TASK FORCE REPORT – Jim Donoghue shared the report of the DOE task force on suicide prevention and trauma-informed care, on behalf of Ellen McGinnis-Smith, who is a member of the workgroup. The report is available on the Department of Education website. It was developed pursuant to SF 446, which directed the Iowa Department of Education to work with DHS and IDPH to convene a task force to develop recommendations regarding suicide preventions and trauma-informed care training for persons who hold a license, certificate, authorization, or statement of recognition issued by the Board of Educational Examiners and who provide services to students.

The group met four times, starting on September 20, 2013 and concluding on November 26, 2013. Task force members included Ellen McGinnis-Smith and several others from the DoE, Laura Larkin from DHS, Dean Decker from Kathy Stone's team at IDPH, representatives from AEAs (Area Education Agencies), large, medium, and small school districts, legislators, mental health services providers, and a parent who had lost a child to suicide.

The task force focused on two areas:

1. Making recommendations regarding suicide prevention training that should be required for persons recognized by the Board of Educational Examiners to provide services to children. Also, establishing protocols on how to respond to students at high risk for suicide and how to respond when a death by suicide occurs, as well as providing evidence-based suicide prevention training to all school staff who work with children and youth.
2. Making recommendations regarding training on trauma-informed care for pre-K through 12th grade school staff. Also, helping staff understand all types of trauma, understand its impact on social, emotional, and cognitive development, creating awareness of symptoms and triggers resulting from trauma, developing skills in supporting students and recognizing and avoiding actions that are like to re-traumatize.

Jim Donoghue noted that trauma in childhood, or adverse children experiences (ACEs) are experiences that harm a person's ability to function in social, cognitive, and emotional areas. As the report indicates, when a study compared people with no ACEs to people with just one ACE, there was an 80% increase in the number of attempted suicides in that group. With four or more ACEs, the increase in number of suicide attempts was 1120%. The report also discusses using trauma-informed approaches to change how a school (or other organization) responds to those who are, or may be, at risk for experiencing trauma.

The American Foundation of Suicide Prevention conducted a review of state suicide prevention initiatives in 2012 and Iowa was the only state in the nation without any statewide suicide prevention activity. That changed when in October 2013 the Iowa Department of Public Health received a $440,000 per year (3 year) grant from SAMHSA (Substance Abuse and Mental Health Services Administration) to promote suicide prevention efforts for youth and young adults. It will be used to implement evidence-based screening and assessment for suicide risk statewide by substance abuse treatment programs. It will also offer free web-based training for all middle and high school educators in Iowa and use social media to educate youth and increase referrals for services.

Key concerns:

- What do schools do once they identify students who are at risk?
- What supports are available to assist vulnerable students, families, and teachers?
- Where do schools go to get answers to these questions?

Recommendations:

1. Require districts to adopt protocols for helping students at high risk of suicide and in responding to a suicide death.
2. Fund training in evidence-based suicide prevention and evidence-based trauma-informed care for all school personnel who work with children (pre K-12).
3. Establish and fund an Iowa Center for Suicide Prevention with at least four funded suicide prevention specialists. The initial responsibilities of the Center will include:
    a. Leading a public-private coalition of state and local agencies, community groups, organizations (including AEAs), and individuals with the goal of supporting statewide suicide prevention, awareness, intervention, and resources.
    b. Infuse best practices and current research into evidence-based training for school personnel.
    c. Develop a tiered training protocol including universal, targeted, and intensive training.
    d. Develop model protocols to assist schools in suicide prevention and postvension.

e. Develop recommendations for social and emotional learning programs and supports for schools.
f. Encourage content to be included in pre-service teacher training.

Long-term goals of the Center:

a. Coordination of a comprehensive community effort of suicide prevention to identify and develop supports for students at risk of suicide.
b. Developing evidence-based training.
c. Identification of unmet need in school and community social and emotional learning supports.
d. Support schools in providing suicide prevention and trauma-informed care.
e. Identify resources for students identified as at risk for suicide through community involvement.

4. Implement recommendations above beginning July 1, 2015.
5. A financial appropriation of $500,000 to fund the Iowa Suicide Prevention Center.

Ron Clayman commented that he likes the idea of peer involvement in the planning and development of protocols. Teresa Bomhoff said she believes it is important to work with people who have lived experience with mental illness and family members who can identify what will work and what will not work. Jim Rixner added that the involvement of students is also important. He said he is glad to see a broad based approach and that it is not just limited to people who are known to have experienced trauma. Jim Donoghue said this is intended to make teachers more aware of how they respond to students and incidents and how they can better reach the students.

Jim Rixner said he is concerned about schools implementing this when they have so many things going on, including a recent emphasis on addressing bullying. Teresa said she sees the issues of bullying and suicide prevention as being tied together, and that both children who are bullied and those who engage in bullying need help. It is all part of a larger effort to make sure that more people understand about mental health needs at a younger age. She said she was pleased to see that the report went beyond what the group was called on to do and really encompasses the whole school.

Sally Nadolsky suggested that IDPH could be invited to talk to the Council about their grant. Kathy Stone indicated that the new person hired under the grant is just starting this month and she would be glad to follow up at a future date.

LeeAnn Russo noted that about 23% of the population IVRS currently services have mental illness and this should be very helpful to young people dealing with trauma or mental illness.

Medicaid Update - Sally Nadolsky gave an update in Iowa Medicaid Enterprise (IME) activities and projects.

The SIM (State Innovation Model) Reports are completed and they are moving forward with the plan and model testing procedures. Sally said that a lot of people came to the table and put in a lot of hard work. She has heard that there is still an unresolved issue about how adults and children fit into the same model.

Joe Sample noted that the BIPP (Balancing Incentives Payment Program) is closely related. It is a "three-legged stool" to balance funding between long-term care institutionalization and community based services to provide long-term care and support. The three legs are:

- No wrong door/single entry point to provide easy coordinated access to services, which will include AAAs (Area Agencies on Aging) and MHDS regions
- Conflict-free case management, which is in the policy development stage
- Core standardized assessment. Magellan has been identified to provide assessments for mental health needs and an RFP (Request for Proposals) is coming out for the other populations

Joe said this effort is more about systems, how programs interact, and how people get into the system. It will help us bring Iowa more in line with the Olmstead principles. Sally Nadolsky said that part of the effort is to build capacity and increase the skills of community providers to better support people outside of institutional care. Jim Rixner said he thinks one of gaps in MHDS Redesign is the transition from acute care to community care and making quality care available to people after leaving an institution. Several Council members expressed their concern about people leaving hospitals and MHIs and yet not being ready to function independently in the community and care for themselves.

Jim Rixner said he believes the Integrated Health Home program is necessary and valuable, but it is not working as envisioned. Jim said the most difficult part is actually finding the people who are eligible and engaging them in the process; none of the providers are even close to getting the number of people in the program that were expected. A number of them are enrolled in a health home program with their FQHC (Federally Qualified Health Center) and it will be disruptive to them to disenroll them from that program and move them to another.

Jim said that his CMHC originally received a list of 1200 names. They found out about 300 were enrolled at the FQHC, then after further effort, found that another 200 were also enrolled at the FQHC. He said they hired staff to support 900 participants and were paid for about 600, but last month were only able to bill for 231. He said they are devoting a tremendous amount of time to locating people, but after a brief initial period are only paid a per member/per month fee from Magellan for those who are enrolled. He noted that other programs are all facing the same issues. Jim said he would like to propose switching to a cost reimbursement method for the first year of the program and then moving to the per member/per month payment method. He said that CMHCs operate with a zero profit margin and need to cover their cost or lay off staff.

Sally said that Magellan is currently working on getting Phase 2 and 3 of the Integrated Health Home rollout going so that the whole state will be covered by July 1.

Sally continued her report with Health Information Technology (HIT), or using electronic health records. She said that many hospitals that have received funding through the provider incentive program and that program is continuing.

The two waivers for the Iowa Health and Wellness Plan (IHAWP) were approved the end of December. The program does not now include non-emergency medical transportation, although CMS (Center for Medicare and Medicaid Services) has said that we have to track any barriers that are caused by the lack of transportation services, so people need to communicate any of those problems they are experiencing to IME. The waiver is only for one year.

The Wellness plan does not include IHHs, but there is the medically exempt provision available for people who qualify. They would then receive the more fulsome benefits of the regular Medicaid state plan, which would also include non-emergency medical transportation. The forms to apply for medical exemption status are available online and if anyone believes they might qualify they should complete the application.

About 60,000 Iowa Care members have been moved to the Iowa Wellness Plan or the Marketplace Plan. About 10,000 remain because they have not provided enough financial information to determine which plan they qualify to join. Sally said all 70,000 Iowa Care members received notices of decision and a lot of them required assistance because they did not understand the changes. Jim Rixner also noted that people who had been receiving county funding for services have gotten letters from their counties saying that as of January 1 they are no longer covered by the county and will need to apply for IHAWP.

Sally said that at this time, population at this time does not have dental care coverage under either plan. An RFP will be issued and DHS will be contacting with dental services providers. IME expects to have dental services available under the two plans by May 1; people will probably receive notices on that in April. Nineteen and twenty—year-olds will be covered under EPSDT (Early Periodic Screening, Diagnosis, and Treatment) for eyeglasses and other things that are included in Medicaid but not in the Wellness Plan. Sally was asked if more insurance providers be coming into the plan. She responded that they could next year, but it is too soon to be certain.

Sally noted that CMS is replacing their ICD-9 code set with ICD-10 (an updated version), which will change all diagnostic codes to make them more specific, and the result is that everyone will essentially have to be re-diagnosed. (ICD stands for International Statistical Classification of Diseases and Related Health Problems.) The number of options will go from about 6000 to about 81,000. The proposed compliance date is October 1, 2014. Jim Rixner commented that this will be equivalent to the international system that has been used in Europe for a number of years.

Sally said that the responses to the second RFP for the MMIS (Medicaid Management Information System) are in and have been reviewed. You may recall that the contract awarded from the first RFP was disallowed through an appeal that went to court. The successful applicant is expected to be announced in February.

ELIAS, the Medicaid eligibility system, is in place but does not have all the capabilities promised, so more work may be done. It should eliminate some of the potential for worker error.

A break for lunch was taken at 12:25 p.m.

The meeting resumed at 1:00 p.m.

BRAIN INJURY ALLIANCE OF IOWA

Geoff Lauer, Executive Director of the Brain Injury Alliance of Iowa, shared a presentation on brain injury and issues related to mental health. Thirty years ago, 50% of people who suffered a brain injury died as a result. Today, less than 22% die as a result of their injury. As more and more people began surviving traumatic brain injury, it became obvious that they often need life-long services and supports but there are not funding streams to serve them. About every ten years, the US military conducts a needs assessment looking forward at the next ten years. In the early 1990s, when it was recognized that brain injury was becoming a significant factor following combat in Kuwait, money was released for the organization of brain injury associations around the country. In 2007, the Iowa legislature also provided some funding that allowed the BIA of Iowa to grow.

Background – Two things happened after the Viet Nam War: (1) A large cadre of trained helicopter pilots came home and were available for work and (2) the medical community learned that that rate of survival for soldiers treated in battlefield hospitals within the first hour after they were injured went up dramatically. This became known as the “golden hour” and hospitals all over the country capitalized on the availability of pilots to create life flights. It also became clear that with closed head brain injuries, it is vital to survivability to relieve the pressure that builds up due to bleeding. More people are surviving, and that means that more people are living with long-term disabilities from brain injuries.

At the same time, there was a growing incidence and awareness of brain injury in sports. Youth athletes have gotten bigger, faster, and stronger with improved nutrition and conditioning, but their brains remain vulnerable to injury. Legislation is being considered to limit contact through football and other contact sports for kids under age fourteen. Research has found that their bodies are affected differently than older youth and adults and that they can have cumulative damage that may be life-long even if they

suffer no major injuries. Geoff noted that just yesterday a court rejected the NFL's proposal for a fund to compensate injured professional football players.

The military has developed good lightweight body armor for soldiers, but it still does not protect the brain well. Brain injury is the signature injury from combat in Iraq and Afghanistan. Currently, between 15% and 23% of service members are returning home with brain injury.

The Nature of Brain Injury – The brain "floats" in cerebral/spinal fluid and there are boney ridges that run down through the ridges of the brain. They are built-in stabilizers that serve as a kind of natural helmet. Now that people often move faster than their bodies were designed to move, those natural protections just are not enough and there is no way to stabilize the brain inside the skull.

There are two kinds of brain injury: (1) acquired and (2) traumatic. Acquired brain injury includes anoxia from near drowning, huffing, suffocation, aneurisms, infections, strokes, and tumors. Traumatic brain injury is caused by an external force that may produce a diminished or altered state of consciousness. Traumatic injuries can be caused by falls, vehicle crashes, sports injuries, assaults, or blast injuries. The number one cause of TBI used to be auto accidents, but as vehicle safety features have improved, the leading cause is now falls. The highest number of falls are among young children and people age 50 or over. For older adults, factors may include medications that interact to cause dizziness.

Brain injury has been called the "silent epidemic." More than 5.3 million Americans live with a disability as a result of a traumatic brain injury. About 2500 Iowans are hospitalized with brain injuries each year, and about 95,000 Iowans live with long term BI, and because the brain controls so much of our social interactions with each other, brain injury impacts the lives of many other people as well.

After a brain injury, people report experiencing a lack of information, services, and supports that can lead to incarceration, mental health issues, homelessness, divorce, substance abuse and unemployment.

The severity of the injury does not necessarily predict the severity of the outcome. Each injury is unique. A person who sustains a mild brain injury may have ongoing difficulties for many years and a person with a severe brain injury may make significant improvement. Mental health overlaps with brain injury. It is estimated that 44% of people with acquired brain injury also have a psychiatric diagnosis.

Brain injury can cause neuro-structural changes. Direct effects of brain injuries include cognitive and motor disturbances, emotional disorders, increased impulsivity, depression, rigidity, and hyperactivity. Over time, the implications of these effects of brain injury may result in profound personality changes, which may adversely influence mental health. Changes in capabilities and competencies may increase the likelihood of

depression. Suicide rates are higher among people with BI than the general population. Hormonal and endocrine changes can be common after brain injury. Brain injury is often a life-changing event and many survivors experience dramatic and permanent changes that affect their work, income, family life, support network, and quality of life. This may lead to feelings of social isolation, helplessness, and hopelessness.

The Brain Injury Alliance was formed to advocate for people with brain injury because they found themselves without the services they needed, but realized there was a lot of overlap with mental health and conditions such as Alzheimer's.

In brain injury, the damage is neuro-structural rather than neuro-chemical, but the effect on people's lives is very similar. Most people show up with a range of complex co-occurring issues and they need providers that have basic competencies in the areas of brain injury, mental health, intellectual disabilities, and substance abuse. Work is being done to identify the best practices, and the US military is putting money into researching what works best for brain injury recovery. On the average, however, it takes about 17 years for medical research to translate into common practice.

Advocacy wins – Work continues on services for people with Brain Injury. Progress includes community-based neurobehavioral services, the recovery of a Brain Injury Services Program Manager at IDPH, and the expansion of BIA-Iowa.

In 2009, about 50 people with BI were being served out of state at a cost of $12 million per year. Families wanted them closer to home and DHS has been working on getting them into appropriate services here in Iowa. There is now a program of community-based neurobehavioral services offered through three locations in the Des Moines area and one in Johnson County. The community-based program costs about $100,000 less per person per year than the out of state placements. Work is still being done to pass a helmet law in Iowa; we are one of only three states without one. Advocates were also disappointed by the Governor's veto of funding to address the HCBS Waiver waiting list last year.

Clinical screening for brain injury is critical. The concept is to conduct screening in the places where people go for mental health care. In 2005, an IDPH supported screening of community mental health center participants in Iowa City showed that 57% screened positive for brain injury. Screening can lead to a better understanding to plan treatment and better patient information and support.

Geoff said BIA-IA will be working with mental health providers in the regions to help promote screening and would like to work with the Council as well.

Resource Facilitation – Resource Facilitation is a partnership that helps individuals and communities choose, get, and keep information, services, and supports to make informed choices and meet their goals. The Neuro-Resource Facilitators at BIA-IA have more than 25,000 calls and contacts a year.

Danielle Cusack said the NRFs partner with whoever calls in and help them make informed choices about their goals or whatever they are calling about. They also put together tote bags filled with brain injury resource information to give or send out to people. Geoff said the idea for the tote bag came from a needs assessment. They learned that people are not usually ready for the information when they are in the hospital or immediately after the injury, but if they get it in a tote bag they will take it home, put it aside, and get it out when they are ready. The tote bags are free and available at sites around the state.

Danielle said that more than half of what they do is on the phone, and often involves helping people find both formal and natural supports. They follow people who call for a year or until they are ready to stop. Most people they work with are not Medicaid funded and do not have services coming into the home, but need a little support or reminders to get medications refilled and necessary things done. They work to help Iowans live well with brain injury.

BIA-IA also does case consultations on brain injury with providers and conducts prevention activities with helmets. BIA-IA is governed by a board of people with lived experience and family members of people with brain injury. BIA-IA will be asking for $10 million for the MHDS system to provide services for people with BI and they are working with the Arc to get services for people with developmental disabilities. Geoff noted that there is a list of core services for people with BI in the final MHDS Redesign report to the Legislature.

Geoff will share an electronic copy of his Power Point presentation.

DHS/MHDS UPDATE

Laura Larkin presented an update on DHS/MHDS activities.

Mental Health Block Grant – There is no update yet on site visit; there has been no response from the federal review team. The Implementation Report was filed in December. Since SAMHSA went to the new format, there is not much detail included.

Community Services Consultant – Robyn Wilson's position has been filled. Jan Heikes, a former CPC from Appanoose and Winneshiek Counties started December 30.

Regional Formation – Jefferson County lost its appeal to function as a stand-alone one-county region. They have joined the South East Iowa Link Region. Emmet County has joined the County Social Services (CSS) Region.

Timeline:

- Regional Management Plans are due April 1
- 28E agreements must be approved by DHS and signed by the governing board prior to July 1

- Governing boards must be in place prior to July 1
- Executive staff must be identified or hired prior to July 1
- Transition Plans must be approved by DHS prior to July 1

As of this week, the Department has received eight 28E agreements. DHS has a two-step review process and identify anything that needs to be changed.

Equalization Funding:

- 54 counties were eligible for $29.8 million in equalization payments
- 41 counties have received full payments
- 6 counties asked for their full payment to go to paying their State bills
- 3 counties paid their State bills and received additional funds
- 2 counties received partial payments with the rest of the funds held for outstanding bills
- 2 counties have not yet received any equalization payment

Autism Support Program – The administrative rules for the program will go to the MHDS Commission for review and adoption tomorrow. An RFP was issued and Magellan was the successful bidder. The Department is working with them on a contract. The goal is to be able to start services by April 1. The program provides ABA (Applied Behavior Analysis) services to children under age nine with a diagnosis of autism who do not have other funding for the service.

Children's Services Workgroup Final Report – The final report of the Children's Services Workgroup was submitted to the Legislature in November. Last year they recommended a Children's Cabinet and that idea was revamped this year as a Children's Coordinating Council, which is intended to get policy makers together to better coordinate all services that touch the lives of children. They also recommended an advisory council to the Coordinating Council. They also want to look at consolidating or eliminating redundant groups. They identified core services domains for children, and discussed prevention and early intervention to promote good mental health.

Hospital Bed Tracking Report – The report has been submitted to the Legislature. It addresses the development of an electronic system to track the availability of beds statewide and offers some options about how such a system could be set up.

Crisis Stabilization Services – The adult crisis stabilization pilot in the CSS region has been operating for two years, serving people who do not need inpatient treatment, but do need some kind of 24-hour services or supports. A report on the pilot project has been submitted to the Legislature and one of the next steps is writing administrative rules for both facility and community-based crisis stabilization services.

Workforce Workgroup Report – The preliminary report is finished, but Theresa Armstrong has not yet reviewed it.

Integrated Health Homes – The IHH Phase 2 providers were just announced. Phase 2 will be starting services in 27 counties on April 1. Provider meetings for the Phase 3 counties are scheduled during March and April. There are currently eight Phase 1 sites in operation.

Core Standardized Assessment – The RFP is out for a vendor to perform core standardized assessments. The RFP asked for a vendor to conduct SIS (Supports Intensity Scale) for all Medicaid members with intellectual disabilities and suggest appropriate tools to be used for assessing other populations. Proposals are due March 17.

Iowa Health and Wellness Plan – Coverage benefits began January 1. The definition and referral form for medical exemption have been finalized.

Federal HCBS Services Rules – The final federal rules for HCBS services were issued this week. The rules address the meaning of "community" and what characteristics settings must have to be considered community-based. Included are individual choice, integration into the community, person-centered planning, and outcomes of services. These rules could potentially affect how we provide HCBS Waiver services in Iowa.

NEXT MEETING

Teresa Bomhoff said she would explore several suggested agenda items for the next meeting:

- Karen Hyatt with an update on Mental Health First Aid
- More information on the IDPH suicide prevention grant
- Mary Mohrhauser with an update on MH Block Grant contracts
- An introduction to John Gish, a new attorney at DRI

The meeting was adjourned at 3:15 p.m.

Minutes respectfully submitted by Connie B. Fanselow.